IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

September 30, 2010

Tom Moss, Administrator
Preferred Community Homes - Courtyard
615 Second Avenue West
Wendell, ID 83355

Provider #13G057

Dear Mr. Moss:

On **September 16, 2010**, a complaint survey was conducted at Preferred Community Homes - Courtyard. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004710

Allegation #1: Individuals are not receiving active treatment, including physical therapy exercises, due to insufficient numbers of staff.

Finding #1: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations, record review, and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 6 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals.

Observations were conducted for a cumulative 4 hours and 6 minutes across the morning and evening shifts. During that time, 4 direct care staff were noted to be working each of those shifts, and individuals were noted to receive both formal and informal training as identified in their IPPs (Individual Program Plans). Additionally, 3 individuals were selected for review. The individuals' records documented ongoing

program implementation at the assigned rates.

Further, 10 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals who require one-to-one supervision are not one-to-one due to insufficient numbers of staff.

Finding #2: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, observations and staff interviews were completed with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported to the survey team there were 6 individuals residing in the facility, and 4 direct care staff were required on the morning and evening shifts to meet the needs of the individuals. The Administrator stated 2 of the individuals required one-to-one supervision due to maladaptive behaviors.

Observations were conducted for a cumulative 4 hours and 6 minutes across the morning and evening shifts. During that time, 4 direct care staff were noted to be working each of those shifts. Two individuals were noted to be staffed one-to-one. The remaining 2 staff were noted to work with the other 4 individuals. Staffing was maintained for all individuals residing in the facility.

Further, 10 direct care staff were interviewed. All staff stated they were able to meet the needs of the individuals with the current staffing levels.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Inappropriate behavioral interventions are being used by staff.

Finding #3: An unannounced on-site complaint investigation was conducted on 9/13/10 -

9/16/10. During that time, incident/accident report review, investigation review, observations, record review, and staff interviews were completed with the following results:

Incident/accident reports and investigations were reviewed from 7/1/10 - 9/13/10. None of those documents showed inappropriate behavioral interventions were used.

Further, observations were conducted on 9/14/10 for a cumulative 4 hours and 6 minutes. During that time, no inappropriate behavioral interventions were noted to be used with any individuals. Additionally, 10 direct care staff were interviewed during the course of the survey. None of those staff reported inappropriate use of behavioral interventions.

However, the incident/accident reports documented that an individual who engaged in self abuse and required a helmet to protect him, continued to sustain ongoing head injuries because his helmet was not used.

Additionally, during the above noted observations, the individual who required the use of a helmet to protect him from self abuse was noted to be one-to-one with staff. When interviewed, the staff working with the individual reported they had not been trained on the individual's behavioral interventions. An additional staff was interviewed on 9/15/10 at 11:45 a.m. That staff reported she worked one-to-one with the individual and had not been trained on the individual's behavioral interventions.

Three individuals' records were selected for review. One of those records showed the behavior intervention plan for the individual who required the helmet was not sufficiently developed to identify how the helmet could be easily accessed when the individual engaged in self abuse.

Therefore, the allegation was unsubstantiated. However, deficient practice was identified and the facility was cited at W127, W193, W249, and W285.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: A staff person working at the facility does not have legal rights to work in this country.

Finding #4: An unannounced on-site complaint investigation was conducted on 9/13/10 - 9/16/10. During that time, interview with the Administrator was conducted with the following results:

During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator reported the corporate office had received a complaint alleging a staff person working in the facility did not meet legal requirements to do so. The Administrator reported all personnel records were reviewed and found to be in compliance with legal requirements for employment.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0864

September 30, 2010

Tom Moss, Administrator
Preferred Community Homes - Courtyard
615 Second Avenue West
Wendell, ID 83355

RE: Preferred Community Homes - Courtyard, Provider #13G057

Dear Mr. Moss:

Based on the complaint survey completed at Preferred Community Homes - Courtyard on September 16, 2010, by our staff, we have determined that Preferred Community Homes - Courtyard is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Conditions of Participation for Client Protections (42 CFR 483.420); Client Behavior & Facility Practices (42 CFR 483.450). To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Preferred Community Homes - Courtyard to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **October 31, 2010**. **To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than October 20, 2010**.

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Also, pursuant to the provisions of IDAPA 16.03.11.320.04, Preferred Community Homes - Courtyard ICF/MR is being issued a Provisional Intermediate Care Facility for Persons with Mental Retardation license. The license is enclosed and is effective September 16, 2010, through January 14, 2011. The conditions of the Provisional License are as follows:

1. Post the provisional license.
2. Correct all cited deficiencies and maintain compliance.

Please be aware that failure to comply with the conditions of the provisional license may result in further action being taken against the facility's license pursuant to IDAPA 16.03.11.350.

Be advised that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **October 27, 2010**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
PO Box 83720
Boise, ID 83720-0036
Phone: (208)364-1804
Fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by October 12, 2010. If a request for informal dispute resolution is received after October 12, 2010 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm
Enclosures

October 12, 2010

Nicole Wisenor, Co-Supervisor, Non-Long Term Care
Idaho Department of Health and Welfare
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720

Dear Ms. Wisenor:

Preferred Community Homes – Courtyard alleges compliance with the Medicaid Intermediate Care Center Facility for Persons with Mental Retardation Conditions of Participation on Client Protections, and Client Behavior & Facility Practices.

Preferred Community Homes has accomplished the following in preparation for a revisit:

- The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained.

- Preferred Community Homes has hired a new Administrator that is assigned to the Twin Falls/Wendell area. She has worked with individuals with disabilities since 1993. She has managed staff in group home settings and is a LMSW and has a bachelor's degree in Special Education.

- The supervisor at the Courtyard home has been relieved of her supervisory duties at the other facilities. She is now full time at the Courtyard home. She is expected to work at least two shifts per week on the floor with her staff to provide oversight and training for them.

- Preferred Community Homes has sent experienced QIDP's to the Wendell area to assist with assessment and program revisions. An IPP was held for each individual living in the Courtyard home. Included in the revisions are the Behavior Assessments, Behavior Management Plans as well as the Medication Reduction Plans. Through this process they are teaching the AQIDP in Wendell the appropriate methods for addressing the behavioral needs of the individuals. The IPP's will be completed and implemented by 10/20/10.

- The Individuals that are utilizing behavior modification medications are currently being brought to the Psych Clinic at the corporate office instead of a private

physician. This way changes can be monitored and input can be taken from all team members prior to a medication being implemented.

- As stated in the report the following actions were taken on 9/15/10 to abate the immediate jeopardy: An addendum to the BIP was submitted which gave specific guidelines for individual #1's helmet use, use of a pillow and clear indicators related to individual #1's escalation. Since 9/15/10 Preferred Community Homes has assured that only MANDT certified and staff trained in his Addendum has worked with him. By 9/26/10 all the staffs allowed to work with individual #1 were trained on his BIP. There were some staff that were not MANDT certified and others that were hired after this that were not allowed to work with him. Preferred Community Homes has conducted observations on the AM and PM shifts since 9/15/10 to assure that the BIP has been followed. Preferred Community Homes has assured that weekly behavior meetings have occurred to discuss individual #1's needs. As a result several additional revisions have been made to Individual #1's BIP since the survey team exited the facility.

- All staff in the home are currently being re-trained in regards to all of the revised BIP's. This training will be completed no later than 10/20/10.

If you have any further questions, please feel free to contact me at 208-855-9142

Tom Moss
PCH-Courtyard, Acting Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Leader Monica Nielsen, QMRP Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactivity Disorder ADL - Activities of Daily Living AQMRP - Assistant Qualified Mental Retardation Professional BIP - Behavior Intervention Program IDT - Interdisciplinary Team IPP - Individual Program Plan LPN - Licensed Practical Nurse MAR - Medication Administration Record OCD - Obsessive Compulsive Disorder OSHA - Occupation Safety Health Association Mandt - A physical restraint system RN - Registered Nurse RSC - Residential Service Coordinator QMRP - Qualified Mental Retardation Professional	W 000	**W 000 INITIAL COMMENTS** "Preparation and implementation of this plan of correction does not constitute admission or agreement by Courtyard with the facts, findings or other statements as alleged by the state agency dated September 16, 2010. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Courtyard – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action." RECEIVED OCT 20 2010 FACILITY STANDARDS	
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observations, review of the facility's policies and procedures, incident/accident reports, record review, and staff interviews it was determined the facility failed to provide the necessary client protections and ensure steps	W 122	**W 122 483.420 CLIENT PROTECTIONS** Please refer to W124 as it relates to the facility's failure to ensure that individual's written informed consent for restrictive interventions were accurate.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tom Mays — TITLE: Administrator — (X6) DATE: 10/18/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that o[ther] safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days f[ollowi]ng the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 122	Continued From page 1 were taken to protect an individual from self abuse. These failures resulted in a lack of effective systems to prevent an individual from being subjected to self abuse resulting in ongoing head injuries and constituted serious and immediate jeopardy to the health and safety of an individual. The findings include: 1. Refer to W124 as it relates to the facility's failure to ensure an individual's written informed consent for restrictive interventions was accurate. 2. Refer to W127 as it relates to the facility's failure to ensure an individual was not subjected to ongoing self abuse. 3. Refer to W249 as it relates to the facility's failure to ensure an individual's behavior plan was implemented and followed as written.	W 122	**Please refer to W127 as it relates to the facility's failure to ensure an individual was not subjected to ongoing self abuse.** **Please refer to W249 as it relates to the facilities failure to ensure an individual's behavior plan was implemented and followed as written.**	
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 1 of 3 individuals (Individual #3) whose written informed consents were reviewed. This resulted in a lack of information being	W 124	**W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS** **Preferred Community Homes held an IPP meeting for individual #3 on 9/28/10. An experienced QMRP was sent to the home to do observations and assist in writing the IPP. One part of the revisions will be Individual #3's Written Informed Consents for Risperidone and Geodon to assure that they contain sufficient information for his guardian to make an informed treatment decision.** **A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 2 provided to an individual's guardian regarding restrictive interventions. The findings include: 1. Individual #3's 2/16/10 IPP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. Individual #3's Physician's Order, dated 8/10, documented he received Risperidone (an antipsychotic drug) 3 mg each evening and Geodon (an antipsychotic drug) 80 mg each evening. Individual #3's Written Informed Consent for Risperidone, dated 8/24/10, stated the drug "should further increase [Individual #3's] ability to follow instructions and increase his time on task." A second Written Informed Consent, dated 8/24/10, for Geodon stated the drug was to "continue to assist [Individual #3] in controlling his maladaptive behaviors." Additionally, the Written Informed Consent for Geodon stated "Since arriving at [facility name] [Individual #3] has undergone several medication changes to assist him with both his behaviors, and his Autistic traits." Individual #3's Psychotropic Medication Reduction Plan, dated 8/26/10, stated both drugs were for "Inattentive behaviors." The criteria for reduction listed for both drugs was for Individual #3 to "independently follow a set of one step directions 1 time repeat 3 times [sic] 80% of the trials per month for 6 consecutive months." Individual #3's Written Informed Consents did not clearly define the intended outcome of the drug (i.e. time on task versus following a one step	W 124	**Administrative staff including the importance of assuring adequate information is included in the written informed consents.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes review of tbe written informed consents to verify that sufficient information is included within the consents so the guardian can make informed treatment decisions. In the event that it is discovered that a written informed consent does not have sufficient information included, immediate training will be provided to the QMRP and corrections will be made. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 124	Continued From page 3 direction for Risperidone and undefined maladaptive behaviors versus following a one step direction for Geodon). Without clear information about the intended outcome of the drugs, it would not be possible for Individual #3's guardian to make an informed decision regarding their use. During an interview on 9/16/10 from 1:05 - 1:50 p.m., the Administrator, who was also the Acting QMRP, stated he did not know the specific reason Individual #3 was receiving Risperidone or Geodon. The Administrator stated the drugs were for maladaptive behaviors, but the specific behaviors were not clear and were not defined in the consents. The Administrator stated the only thing that was accurate in Individual #3's Written Informed Consents was the information related to the side effects of the drugs. The facility failed to ensure Individual #3's Written Informed Consents for Risperidone and Geodon contained sufficient information for his guardian to make informed treatment decisions.	W 124		
W 127	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews, it was determined the facility failed to ensure an individual was not subjected to ongoing self abuse for 1 of 1 individual (Individual #1) reviewed, who engaged in hitting his head and	W 127	**W 127 483.420(a)(5) PROTECTION OF CLIENTS RIGHTS** As stated in the report the following actions were taken on 9/15/10 to abate the immediate jeopardy: An addendum to the BIP was submitted which gave specific guidelines for individual #1's helmet use, use of a pillow and clear indicators related to individual #1's escalation. Since 9/15/10 Preferred Community Homes has assured that only MANDT certified and staff trained in his Addendum has worked with him. By 9/26/10 all the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 4 required a helmet for protection. This resulted in an individual sustaining ongoing head injuries from hitting his head which placed him in immediate jeopardy. The findings include: 1. The facility's Abuse, Neglect, Mistreatment and Injuries from an Unknown Source policy, dated 2/10/09, defined self abuse as "The behavior of an individual that threatens his/her own safety. This includes but is not limited to intentional injury to oneself resulting in tissue damage, head banging..." During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator informed the survey team that Individual #1 required one-to-one supervision due to maladaptive behavior. Individual #1's IPP, dated 3/12/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. Individual #1's BIP, dated 3/12/10, stated "[Individual #1] will remain safe by being provided with one to one staffing within arm's length, during waking hours..." His BIP stated his maladaptive behaviors included self abuse which was defined as biting self, hitting self, and head banging. His BIP stated if he showed signs of becoming agitated (defined a getting an angry look on his face), staff were to show him the feeling cards (Happy, Sad, and Angry) and have him pick a feeling card that best described how he was feeling. If he attempted to bang his head, his helmet was to be used for up to two minutes at a time to help keep him safe from injury.	W 127	staffs allowed to work with individual #1 were trained on his BIP. There were some staff that were not MANDT certified and others that were hired after this that were not allowed to work with him. Preferred Community Homes has conducted observations on the AM and PM shifts since 9/15/10 to assure that the BIP has been followed. Preferred Community Homes has assured that weekly behavior meetings have occurred to discuss individual #1's needs. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all consumers are to be assisted to remain safe at all times. The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations in maintained. One part of the Quality Assurance measures includes reviewing Incident and Accident reports and doing observations to assure that each consumer within the facility is safe. In the event that a safety concern is identified, the Assistant to the Regional Administrator has been given the instruction to take immediate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 5 a. Individual #1's Incident/Accident Reports and Behavior Slips, dated 1/5/10 and 7/10 - 9/7/10, showed he continued to sustain head injuries from hitting his head, and his BIP was not implemented, as follows: - 1/5/10 at 4:25 p.m.: Individual #1 "went into a behavior" and "made himself fall backwards." According to the Report, he fell to the ground, hit his head on a chair, and sustained a cut to the back of his head. However, his Nurse's Note, dated 1/5/10, stated "Res (Resident) went into behavior banged head on chair and then on corner of wall as per staff. Upon assessment of back of head [sic] had wound approx (approximately) 1 [inch] to 1 ½ [inch] long." Individual #1 was transported to the local hospital where 8 staples were inserted to close the wound. Further, the corresponding hospital report, dated 1/5/10, stated Individual #1 struck his head on the ground and sustained a 3 cm laceration to the occipital (back lower part of the skull) scalp which required staples. The hospital report stated "Whenever he becomes angry he throws himself to the floor and beats his head on the ground. This is apparently a chronic manifestation of his anger." However, the attached Behavior Slip, dated 1/5/10, showed Individual #1 also hit his head on the wall 4 times. It was not documented whether this happened before or after the fall. Further, the Behavior Slip showed only verbal cues and open hand blocking were used; it was documented that his feeling cards and helmet were not used as per his BIP.	W 127	corrective action and remain in the facility until each consumer is safe from harm. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will he assisting with Quality Assurance measures. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 6 - 7/7/10 at 3:50 p.m.: Individual #1 dropped and hit his head on the floor. He "reopened head injury" resulting in a ½ inch abrasion. According to the report, a team meeting was to be held "to try to brainstorm on alternative things to do." However, the corresponding Behavior Slip, dated 7/7/10, showed he hit his head on the floor 2 times. Further, the Behavior Slip showed verbal cues, open hand blocking, and body positioning were used; it was documented that his feeling cards and helmet were not used as per his BIP. - 7/12/10 at 9:30 a.m.: Individual #1 "darted" out the front door. When staff blocked him, he sat down on the sidewalk and hit his head on the cement. He "reopened cut on forehead" resulting in a ½ inch abrasion to his upper middle forehead. However, the corresponding Behavior Slip, dated 7/12/10, showed he hit his head on the floor 2 times. Further, the Behavior Slip showed verbal cues and body positioning were used; it was documented that his feeling cards and helmet were not used as per his BIP. - 8/2/10 at 3:00 p.m.: Individual #1 hit the back of his head on the wall and on the kitchen floor. No apparent injury was sustained. However, the corresponding Behavior Slip, dated 8/2/10, showed he hit his head on the wall 2 times, and hit his head on the floor 3 times. Further, the Behavior Slip documented "no" next to the question as to whether his BIP was followed as written.	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 7 - 8/22/10 at 1:50 p.m.: Individual #1 hit his head on the living room wall. There was no apparent injury. According to the corresponding Investigation Report "[Individual #1's] team has recently met and made the decision to continue to provide him with one to one staffing to help him remain safe while in his environment." However, the corresponding Behavior Slip, dated 8/22/10, stated he hit his head and documented "no" next to the question as to whether his BIP was followed as written. - 8/31/10 at 6:30 p.m.: Individual #1 was blocked from going outside. He hit his head on the dining room door resulting in a ½ inch abrasion with a 1 ½ inch diameter lump. However, the corresponding Behavior Slip, dated 8/31/10, showed he hit his head on the door 3 times, and "we got him away from the door [sic] he sat on the floor [sic] started to hit his head with his hand. [Staff's name] told him to go to his room so he went to his room and hit his head on the door hard." Further, the Behavior Slip showed verbal cues, open hand blocking, and body positioning were used; it was documented that his feeling cards and helmet were not used as per his BIP. - 9/1/10 at 1:00 p.m.: Individual #1 "got out the gate" [sic] and hit his head on the concrete driveway. He "opened scabbed forehead" resulting in "½ inch long [sic] reopened from 8/31/10." There was no corresponding Behavior Slip. - 9/1/10 at 4:00 p.m.: Individual #1 "got out the	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 8 gate" [sic] and hit his head on the concrete driveway. He "opened scabbed forehead" resulting in an "abrased [sic] area now 1 inch in diameter." There was no corresponding Behavior Slip. - 9/2/10 from 2:00 - 3:00 p.m.: Individual #1 "banged his head on the sidewalk and on the dirt" resulting in "another ½ cm abrasion to forehead, lump 2 [inches] diameter mushy poss (possibly) fluid filled." Individual #1 was taken to the hospital for evaluation. However, there were three corresponding Behavior Slips, dated 9/2/10, which showed the following: - At 2:00 p.m.: He hit his head on the ground 2 times; it was documented "no" next to the question as to whether his BIP was followed as written. - At 2:30 p.m.: He hit his head on the ground 2 times; it was documented "no" next to the question as to whether his BIP was followed as written. - At 3:30 p.m.: He hit his head on the table 1 time; it was documented "no" next to the question as to whether his BIP was followed as written. According to an Investigation Report, dated 9/2/10, Individual #1 was taken to the hospital to have his head injury assessed. The corresponding Health Status Report showed ice (20 minutes on and 20 minutes off), Tylenol (a nonopioid analgesic drug) 650 mg that evening and again the following morning, and monitoring for vomiting, seizures, sleepiness and	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 9 disorientation were ordered. - 9/4/10 at 5:30 p.m.: Individual #1 ran outside and "banged his head on the grass 5 times." There were no apparent injuries. The corresponding Behavior Slip, dated 9/4/10, stated he hit his head on the grass 5 times and documented "no" next to the question as to whether his BIP was followed as written. - 9/7/10 at 2:45 p.m.: Individual #1 "went in to a behavior" and staff stopped him from going outside. "He went to the ground" and hit his head on the dining room floor. He "reopened the cut on his forehead." According to the Nursing Follow-Up section of the report, he sustained a "¼ inch reopen old wound [sic]." There was no corresponding Behavior Slip. After reviewing Individual #1's Incident/Accident reports the evening of 9/13/10, the Administrator, AQMRP, and RSC, who were present in the facility's office, were asked how the facility was protecting Individual #1 from ongoing head injuries. They were unable to answer. When asked where the helmet was kept, the AQMRP and RSC both stated it was kept either in Individual #1's bedroom or on top of the entertainment center in the living room. When asked what staff were to do if the head banging occurred in other locations, they were unable to answer. Individual #1 required one-to-one arm's length supervision and a helmet to protect him from injuries when he hit his head. However, he continued to sustain ongoing head injuries and	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 10	W 127		

documentation showed his helmet was not used. Further, his helmet was not kept within easy access of his staff and his BIP was not sufficiently developed to include directions to staff about the locality of the helmet. Additionally, documentation showed his BIP was not implemented or followed as written.

b. During an observation on 9/14/10 at 7:26 a.m., Individual #1 walked into the kitchen and it was noted he had two small eraser-sized scabs on the middle of his forehead with approximately 1 and ½ inches of slightly raised scar tissue surrounding the scabs. Individual #1 was asked about his helmet and agreed to show it to the survey team. The staff person working with Individual #1 retrieved the helmet from Individual #1's backpack which she was carrying. The helmet was a full-faced motocross helmet. When asked where the helmet was usually kept, the staff stated it was usually kept in Individual #1's bedroom or on top of the entertainment center in the living room, but they were told by the AQMRP earlier that morning that staff should keep it on their person at all times. It was noted that Individual #1 required assistance from staff to put on the helmet as it required two downward tugs before it was on. Staff reported it was "a little snug."

On 9/14/10 at 2:45 p.m., the survey team was informed by the Administrator that he heard about the fitting of Individual #1's helmet earlier that morning and had purchased a new one because the helmet Individual #1 had was too small.

Individual #1's helmet did not fit him such that it could be easily applied if he became agitated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 11 c. During an observation at the facility on 9/14/10 at 2:55 p.m., the staff person assigned to Individual #1 was asked about her training. She reported it was her first time working with Individual #1. When asked about his BIP, she stated she did not know the plan but believed he head banged and cried. She reported if he banged his head, they were to put the helmet on Individual #1 for 2 minutes. When asked, the staff person reported she was not Mandt certified. It was noted she had Individual #1's backpack on her person. The Administrator was interviewed about staffing assignments on 9/14/10 at 3:40 p.m. He reported the RSC made the assignments. The RSC, who was present, was asked about criteria used when making staffing assignments. She stated she did not use any criteria to make decisions; she stated she "just rotate staff." On 9/15/10 at 11:45 a.m., Individual #1 and his assigned staff person were noted to be walking down the hill towards the facility. Neither Individual #1 nor his staff was carrying the helmet or backpack. The staff was asked, at that time, about her training. She reported she did not work with Individual #1 very often. When asked about Individual #1's BIP, she stated she talked to him and tried to keep him happy. She stated his behaviors consisted of running out the door, head banging, and biting himself. She reported if he hit his head, she blocked with her hand. She stated she thought he had a helmet and stated it was in his bedroom and "it's always kept there." The staff stated that if he continued head banging, they were to tell him that they were going to put on the helmet. The staff person reported she was not Mandt certified. It was noted that no other	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 12 direct care staff were present in the facility. Staff assigned to Individual #1 were not sufficiently trained on his BIP such that they could appropriately intervene and protect him from self abuse. Further, the RSC did not consider staffs' training or knowledge of Individual #1's BIP when making staff assignments. d. Review of Individual #1's Behavior Slips, dated 7/1/10 - 9/7/10, contained documentation that his BIP was not being implemented as written. When asked, the AQMRP stated on 9/15/10 at 12:45 p.m., she was aware the documentation showed Individual #1's BIP was not being implemented as written and his helmet was not being used. When asked, the QMRP stated on 9/15/10 at 1:00 p.m., if it was noted in the documentation that Individual #1's BIP was not implemented or followed, he would have called a team meeting. The QMRP reported they had team meetings but did not document them. Individual #1's BIP was not implemented or followed as written. The AQMRP was aware of the issue. However, there was no documented evidence that the QMRP adequately addressed the issue. In sum, Individual #1 required one-to-one arm's length supervision and a helmet to protect him from injuries when he hit his head. However, he continued to sustain ongoing head injuries and his helmet was not used. Further, the helmet did not fit him appropriately and the helmet was not kept with his staff person. Staff working with Individual #1 were not Mandt certified and were not adequately trained on his BIP. Behavior Slips	W 127		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 127	Continued From page 13 documented the BIP was not implemented or followed as written and appropriate corrective action was not taken to resolve the issue. The cumulative effect of these deficient practices placed Individual #1 in immediate jeopardy due to the potential for him to sustain serious harm, impairment or death, caused by self injury. Note: On 9/15/10 at 5:50 p.m., the facility submitted an immediate Plan of Correction, dated 9/15/10, which showed an addendum was written for Individual #1's BIP that included appropriate helmet use, use of the safety pillow, and clear indicators related to Individual #1's escalation. The Plan stated all staff working with Individual #1 would be Mandt certified and trained on the addendum before working with Individual #1, and that all staff would be trained by 9/26/10. Further, the Plan stated observations would be conducted by management staff, at least once in the morning and once in the evening, to ensure Individual #1's BIP was followed. The Plan stated a weekly behavior meeting would occur in order to evaluate Individual #1's data and incident reports with revisions to his BIP, if necessary. Based on observations and staff interviews conducted the evening of 9/15/10 and the morning of 9/16/10, it was determined the immediate jeopardy was abated.	W 127		
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by:	W 137	**W 137 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS** **The home supervisor will be provided with additional training in regards to assuring that client personal possessions are accurately accounted for and kept secure.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 137	Continued From page 14 Based on record review and staff interviews, it was determined the facility failed to ensure sufficient systems had been developed and implemented to ensure individuals' personal possessions were accounted for and secured for 5 of 6 individuals (Individuals #1, #2, #3, #5 and #6) whose Personal Inventories were reviewed. That failure had the potential to impact all individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals' possessions to be lost, stolen, or destroyed without appropriate interventions being implemented. The findings include: Individuals #1 - #6s' Personal Inventory forms were reviewed on 9/15/10. The forms stated "A full inventory needs to be done in March, May, September and December for every client." However, when asked about the forms, the RSC stated on 9/15/10 from 6:20 - 6:50 p.m., she did not know how frequently the forms were to be completed. A review of the forms documented full inventories had not been completed as required, as follows: - Individual #1's Personal Inventory was last completed on 9/8/09. - Individual #2's Personal Inventory was last completed on 9/8/09. - Individual #3's Personal Inventory was last completed on 5/4/09. - Individual #5's Personal Inventory was last completed on 9/10/09. - Individual #6's Personal Inventory was last completed on 9/18/09. Additional Personal Inventory forms for	W 137	**A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that personal possessions are accurately accounted for and kept secure.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations in maintained. One part of the Quality Assurance measures includes reviewing that personal possessions are inventoried and kept safe. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 137	Continued From page 15 Individuals #1 - #6 were reviewed and showed various clothing items had been added and discarded since the full inventories were completed. However, there was no documentation of what happened to discarded items. When asked during an interview on 9/15/10 from 6:20 - 6:50 p.m., the RSC stated staff would bag individuals' worn or torn clothing for disposal or storage, and at that time, staff were to complete an additional Personal Inventory form to document the items removed. The RSC stated no one verified what items had been removed by staff. When asked, the RSC stated it would not currently be possible to ensure staff were not taking individuals' belongings for their own use. The Administrator, who was present during the interview, stated the RSC was responsible for ensuring Personal Inventory forms were completed quarterly. When asked, the Administrator stated the facility would be unable to ensure individuals' belongings were accounted for and secured with the current implementation of the system. The facility failed to ensure individuals' personal possessions were accurately accounted for and kept secure.	W 137		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, review of the facility's	W 159	**W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL** A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 16 policies and procedures, accident/incident reports, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination which directly impacted 3 of 3 individuals (Individuals #1 - #3) reviewed, and had the potential to impact 6 of 6 individuals (Individuals #1 - #6) residing in the facility. That failure resulted in individuals not receiving the necessary assessments, training, and monitoring required to meet their behavioral needs. The findings include: 1. Individual #1's BIP, dated 3/12/10, stated the RSC, AQMRP, and QMRP were to monitor and track all behaviors throughout the workweek and discuss behaviors on the monthly AQMRP progress notes. When asked for the notes, the AQMRP reported on 9/15/10 at 12:45 p.m., notes had not been completed for any individuals since 6/10. 2. Refer to W124 as it relates to the facility's failure to ensure the QMRP ensured an individual's written informed consents for restrictive interventions were accurate. 3. Refer to W127 as it relates to the facility's failure to ensure the QMRP ensured an individual was not subjected to ongoing self abuse. 4. Refer to W137 as it relates to the facility's failure to ensure the QMRP ensured individuals' personal possessions were accounted for. 5. Refer to W193 as it relates the facility's failure to ensure the QMRP ensured staff demonstrated sufficient skills to consistently implement an	W 159	**importance of assuring that all progress notes are kept up to date as specified in each BIP.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations in maintained. One part of the Quality Assurance measures includes reviewing that program data is reviewed and revised as necessary.** **Please refer the plans of correction given for W124, W127, W137, W193, W207, W214, W227, W237, W239, W249, W260, W278, W285, W289, W312 and W313.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 17 individual's Behavior Intervention Program. 6. Refer to W207 as it relates to the facility's failure to ensure the QMRP ensured appropriate facility staff participated in interdisciplinary team meetings. 7. Refer to W214 as it relates to the facility's failure to ensure the QMRP ensured behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 8. Refer to W227 as it relates to the facility's failure to ensure the QMRP ensured behavioral objectives were developed to address an individual's maladaptive behaviors. 9. Refer to W237 as it relates to the facility's failure to ensure the QMRP ensured data collection was sufficient to determine the efficacy of individuals' behavior intervention strategies. 10. Refer to W239 as it relates to the facility's failure to ensure the QMRP ensured the replacement plans for individuals' maladaptive behavior was developed to meet their behavioral needs. 11. Refer to W249 as it relates to the facility's failure to ensure the QMRP ensured an individual's behavior plan was implemented as written. 12. Refer to W260 as it relates to the facility's failure to ensure the QMRP ensured individuals' IPPs were revised as necessary. 13. Refer to W278 as it relates to the facility's failure to ensure the QMRP ensured less	W 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 159	Continued From page 18 restrictive interventions were systematically tried and proven to be ineffective prior to implementing restrictive interventions. 14. Refer to W285 as it relates to the facility's failure to ensure the QMRP ensured that techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure and individual's safety, welfare and civil and human rights were protected. 15. Refer to W289 as it relates to the facility's failure to ensure the QMRP ensured that techniques used to manage inappropriate behavior were incorporated into the program plans. 16. Refer to W312 as it relates to the facility's failure to ensure the QMRP ensured behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed. 17. Refer to W313 as it relates to the facility's failure to ensure the QMRP ensured behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs.	W 159		
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by:	W 193	**W 193 483.430(e)(3) STAFF TRAINING PROGRAM** Preferred Community Homes has assessed the number of supervisors assigned to each facility. The Courtyard facility currently has a supervisor specifically assigned only to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 19 Based on observation, record review, and staff interviews it was determined the facility failed to ensure staff demonstrated the skills and competencies to administer interventions for 1 of 2 individuals (Individual #1) whose behavior intervention program was reviewed. This resulted in staff being insufficiently trained to address an individual's self abuse. The findings include: 1. Individual #1's IPP, dated 3/12/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. His BIP, dated 3/12/10, stated "[Individual #1] will remain safe by being provided with one to one staffing within arm's length, during waking hours..." His BIP stated his maladaptive behaviors included uncooperative behavior (defined as refusing to listen and follow directions and dropping to the floor), physical aggression (defined as hitting, biting, pinching, scratching, kicking, shoving, and head butting) self abuse (defined as biting self, hitting self, and head banging) and elopement (defined as leaving the facility without staff). His BIP stated if he attempted to bang his head, his helmet was to be used for up to two minutes at a time to help keep him safe from injury. His BIP stated if he left the facility and sat somewhere that was unsafe (the middle of the road or parking lot), staff were to use his gait belt and/or a 2 person walking-moving restraint to immediately remove him from the area to ensure his safety.	W 193	it. The supervisor is assigned to work two shifts per week on the floor with the direct care staff. With a supervisor assigned to the home, the staff within the home will receive more training and oversight. As stated in the report the following actions were taken on 9/15/10 to abate the immediate jeopardy: Ann addendum to the BIP was submitted which gave specific guidelines for individual #1's helmet use, use of a pillow and clear indicators related to individual #1's escalation. Since 9/15/10 Preferred Community Homes has assured that only MANDT certified and staff trained in his Addendum has worked with him. By 9/26/10 all the staffs allowed to work with individual #1 were trained on his BIP. There were some staff that were not MANDT certified and others that were hired after this that were not allowed to work with him. Preferred Community Homes has conducted observations on the AM and PM shifts since 9/15/10 to assure that the BIP has been followed. Preferred Community Homes has assured that weekly behavior meetings have occurred to discuss individual #1's needs. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 20 Individual #1's Incident/Accident Reports and Behavior Slips, dated 1/5/10 and 7/10 - 9/7/10, showed he continued to sustain head injuries from hitting his head and his BIP was not implemented as written. During an observation on 9/14/10 at 7:26 a.m., Individual #1's one-to-one staff was asked about Individual #1's helmet. The staff stated it was usually kept in Individual #1's bedroom or on top of the entertainment center in the living room, but they were told by the AQMRP earlier that morning that staff should keep it on their person at all times. During an observation at the facility on 9/14/10 at 2:55 p.m., the staff person assigned to Individual #1 was asked about her training. She reported it was her first time working with Individual #1. When asked about his BIP, she stated she did not know the plan but believed he head banged and cried. She reported if he banged his head, they were to put the helmet on Individual #1 for 2 minutes. When asked, the staff person reported she was not Mandt certified. It was noted she had Individual #1's backpack on her person. The Administrator was interviewed about staffing assignments on 9/14/10 at 3:40 p.m. He reported the RSC made the assignments. The RSC, who was present, was asked about criteria used when making staffing assignments. She stated she did not use any criteria to make decisions; she stated she "just rotate staff." On 9/15/10 at 11:45 a.m., Individual #1 and his assigned staff person were noted to be walking down the hill towards the facility. Neither	W 193	receives training and oversight to be able to provide optimal care. The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing staff training records and talking with staff about their training to verify that staff receives adequate training. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 193	Continued From page 21 Individual #1 nor his staff was carrying the helmet or backpack. The staff was asked, at that time, about her training. She reported she did not work with Individual #1 very often. When asked about Individual #1's BIP, she stated she talked to him and tried to keep him happy. She stated his behaviors consisted of running out the door, head banging, and biting himself. She reported if he hit his head, she blocked with her hand. She stated she thought he had a helmet and stated it was in his bedroom and "it's always kept there." The staff stated that if he continued head banging, they were to tell him that they were going to put on the helmet. The staff person reported she was not Mandt certified. It was noted that no other direct care staff were present in the facility. The facility failed to ensure staff assigned to Individual #1 were sufficiently trained on his BIP such that they could appropriately intervene and protect him from self abuse.	W 193		
W 207	483.440(c)(2) INDIVIDUAL PROGRAM PLAN Appropriate facility staff must participate in interdisciplinary team meetings. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure appropriate facility staff participated in the IDT meetings for 3 of 3 individuals (Individuals #1 - #3) whose IPPs were reviewed. This resulted in the potential for a lack of comprehensive information being provided in the development of IPPs and a lack of opportunities for the IDT members to consult with one another and to exchange information. The findings include:	W 207	**W 207 483.440(c)(2) INDIVIDUAL PROGRAM PLAN** **Preferred Community Homes held IPP meetings for all individuals on 9/28/10. An experienced QMRP was sent to the home to coordinate the IPP meetings. The Administrator verified that the LPN and a direct care staff participated in the IPP meetings. At the time of the meetings the AQMRP received training in regards to the importance of having appropriate staff attend the meetings.** **A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 207	Continued From page 22 1. Individual #3's 2/16/10 IPP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. He was a ward of the state and had a state appointed Case Manager. Individual #3's IPP showed himself, his Case Manager (via phone), the Administrator, the QMRP, the AQMRP, and the RSC attended his IPP. There was no evidence direct care staff or nursing personnel were encouraged to participate in the meeting. When asked about the attendance of direct care staff, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., that the problem was identified about six months ago when the parent company conducted a quality assurance survey. 2. Individual #1's IPP, dated 3/12/10, showed himself, his parents, the Administrator, the QMRP, the AQMRP, and the Behavior Specialist (via phone) attended his IPP. There was no evidence that direct care staff or nursing personnel were encouraged to participate in the meeting. When asked about the attendance of direct care staff, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., that the problem was identified about six months ago when the parent company conducted a quality assurance survey. 2. Individual #2's IPP, dated 4/29/10, showed	W 207	**10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that adequate staff participates in the IPP meetings.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing the IPP's to assure that adequate staff participates in the meetings. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 207	Continued From page 23 himself, his mother (via phone), the Administrator, the QMRP, the AQMRP, and the RSC attended his IPP. There was no evidence that direct care staff or nursing personnel were encouraged to participate in the meeting. When asked about the attendance of direct care staff, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., that problem was identified about six months ago when the parent company conducted a quality assurance survey. The facility failed to ensure facility staff were encouraged attend the IPP meetings for Individuals #1 - #3.	W 207		
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 2 of 3 individuals (Individuals #2 and #3) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #3's 2/16/10 IPP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. His Physician's Order, dated 8/10, documented	W 214	**W 214 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN** Preferred Community Homes held IPP meetings for all individuals on 9/28/10. An experienced QMRP was sent to the home to coordinate the IPP meetings. During the meetings the behavior assessments were discussed and are being revised based on the current needs of the consumers. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all behavior	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 24 he received Risperidone (an antipsychotic drug) 3 mg each evening and Geodon (an antipsychotic drug) 80 mg each evening. During the entrance conference on 9/13/10 at 3:00 p.m., the previous QMRP stated Individual #3 did not have a behavior management program as he did not exhibit maladaptive behaviors. However, Individual #3's Incident/Accident Reports, dated 7/1/10 to 9/13/10, were reviewed and documented the following: - 8/16/10 at 5:30 p.m.: Individual #3 slapped Individual #2 across the face. - 8/17/10 at 2:40 p.m.: Individual #3 hit Individual #4 on the hand. - 8/17/10 at 3:00 p.m.: Individual #3 hit Individual #4 on the arm. - 8/21/10 at 3:00 p.m.: Individual #3 hit Individual #4 on the arm. Additionally, Individual #3's Behavioral Assessment, dated 4/27/10, stated he displayed the following maladaptive behaviors: - Inattentive-Hyperactive-Impulsive behavior, defined as "easily distracted, fidgety, active all the time, doesn't initiate focus and doesn't think before acting, unable to attend to the majority of tasks or activities for longer than one second unless the programs have physical movement component to them, in which [Individual #3] doesn't have to stay in one place." - Inappropriate Social behavior, defined as "poor social boundaries and no awareness of social cues."	W 214	assessments are kept current to the needs of the consumers. The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing the current assessments to assure that the assessments are up to date and accurate based on the needs of the consumers. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 25 - Uncooperative behavior, defined as "crouching down to the floor to avoid tasks or requests." - Self Stimulatory behavior, defined as "flapping, spinning, running back and forth, jumps up and down when excited, and is tactile sensitive to hot and cold. [Individual #3] wants people to attend to his interests - which change rapidly. He demands people's attention." Individual #3's Behavioral Assessment stated all identified maladaptive behaviors were to be monitored informally with the exception of "Inattentive-hyperactive-Impulsive" behavior, which stated "Formal support provided ADL program for following one-step directions." Further, Individual #3's Behavioral Assessment stated he had a history of "Aggression (hits, bites, pinches, pulls hair), Self abuse (pulls own hair, bites self) and Unusual behavior (bites objects)." The Behavioral Assessment stated historical maladaptive behaviors were "Monitored - no formal behavioral support needed at this time." However, Individual #3's record included a data tracking sheet, dated 2/10, which documented maladaptive behavior totals from 2/1/10 - 2/9/10, as follows: - Slaps = 565 - Attempts to hit = 6 - Grabbing = 276 - Pulling hair = 2 - Screaming = 538 - Non-compliant = 280 - Elopement = 83 - Attempts to elope = 28 - Dropping to ground = 303	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 26 - Running from staff = 79 - Putting objects in mouth = 17 - Throwing objects = 117 - Attempts to throw objects = 2 Additionally, Individual #3's Behavior Slips dated 7/1/10 - 9/15/10, documented the following maladaptive behaviors: 7/19/10 - 7/22/10: - Slaps = 12 - Attempts to hit = 0 - Grabbing = 7 - Pulling hair = 4 - Screaming = 40 - Non-compliant = 23 - Dropping to ground = 37 8/3/10 - 8/22/10: - Slaps = 3 - Attempts to hit = 2 - Grabbing = 1 - Pulling hair = 0 - Screaming = 175 - Non-compliant = 342 - Dropping to ground = 169 No Behavior Slips could be located for 9/10. Individual #3's Behavioral Assessment did not adequately address ongoing maladaptive behaviors. During an interview on 9/16/10 from 1:05 - 1:50 p.m., the Administrator stated Individual #3's maladaptive behaviors were not new, and the assessment needed to be revised. The facility failed to ensure Individual #3's	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 27 behavioral assessment was adequately developed to capture and assess his ongoing maladaptive behaviors. 2. Individual #2's IPP, dated 4/29/10, documented a 19 year old male diagnosed with profound mental retardation and autism. During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator informed the survey team that Individual #2 required one-to-one supervision due to maladaptive behavior. Observations were conducted at the facility on 9/14/10 for a cumulative 4 hours 6 minutes. During that time, Individual # 2 was noted to have a one-to-one staff person assigned to him. However, Individual #2's Behavior Assessment, dated 4/1/10 and revised 8/8/10, did not identify or assess his need for one-to-one staff. When asked, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., Individual #2's Behavior Assessment needed to be revised. The facility failed to ensure Individual #2's behavioral assessment contained clear and comprehensive information.	W 214		
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.	W 227	**W 227 483.440(c)(4) INDIVIDUAL PROGRAM PLAN** Preferred Community Homes held an IPP meeting for individual #3. An experienced QMRP was sent to the home to coordinate the IPP meeting. During the meeting individual #3's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	Continued From page 28 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure individuals' IPPs included objectives to meet their needs for 1 of 3 individuals (Individual #3) whose IPPs and objectives were reviewed. This resulted in a lack of program plans designed to address the needs of an individual in areas most likely to impact his life. The findings include: 1. Individual #3's 2/16/10 IPP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. During the entrance conference on 9/13/10 at 3:00 p.m., the former QMRP stated Individual #3 did not have a behavior management program as he did not exhibit maladaptive behaviors. However, Individual #3's Incident/Accident Reports, dated 7/1/10 to 9/13/10, were reviewed and documented the following: - 8/16/10 at 5:30 p.m.: Individual #3 slapped Individual #2 across the face. - 8/17/10 at 2:40 p.m.: Individual #3 hit Individual #4 on the hand. - 8/17/10 at 3:00 p.m.: Individual #3 hit Individual #4 on the arm. - 8/21/10 at 3:00 p.m.: Individual #3 hit Individual #4 on the arm. Additionally, Individual #3's record included a data tracking sheet, dated 2/10, which documented maladaptive behavior totals from 2/1/10 - 2/9/10,	W 227	behavior needs were discussed and his plan is being revised to include objective for his identified needs. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all behavior assessments are kept current to the needs of the consumers and goals are identified and objectives are written for displayed maladaptive behavior. The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing the current assessments to assure that the assessments are up to date and accurate based on the needs of the consumers and that objectives are written for displayed maladaptive behavior. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	Continued From page 29 as follows: - Slaps = 565 - Attempts to hit = 6 - Grabbing = 276 - Pulling hair = 2 - Screaming = 538 - Non-compliant = 280 - Elopement = 83 - Attempts to elope = 28 - Dropping to ground = 303 - Running from staff = 79 - Putting objects in mouth = 17 - Throwing objects = 117 - Attempts to throw objects = 2 Additionally, Individual #3's Behavior Slips dated 7/1/10 - 9/15/10, documented the following maladaptive behaviors: 7/19/10 - 7/22/10: - Slaps = 12 - Attempts to hit = 0 - Grabbing = 7 - Pulling hair = 4 - Screaming = 40 - Non-compliant = 23 - Dropping to ground = 37 8/3/10 - 8/22/10: - Slaps = 3 - Attempts to hit = 2 - Grabbing = 1 - Pulling hair = 0 - Screaming = 175 - Non-compliant = 342 - Dropping to ground = 169 No Behavior Slips could be located for 9/2010.	W 227		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 227	Continued From page 30 Individual #3's record did not contain plans to address the documented ongoing maladaptive behaviors. During an interview on 9/16/10 from 1:05 - 1:50 p.m., the Administrator stated behavioral interventions for Individual #3 had not been developed. The facility failed to ensure objectives for Individual #3's ongoing maladaptive behaviors had been developed.	W 227		
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the type of data collected was sufficient to determine the efficacy of the intervention strategies for 2 of 2 individuals (Individuals #1 and #2) whose behavior intervention programs and behavior slips were reviewed. By not ensuring appropriate data collection, the facility could not make objective decisions regarding the individuals' success or lack of success. The findings include: 1. Individual #1's IPP, dated 3/12/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits.	W 237	**W 237 483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN** Preferred Community Homes held an IPP meeting for individual #1 and individual #2. An experienced QMRP was sent to the home to coordinate the IPP meeting. During the meeting their behavior needs were discussed and it was determined that a revised data sheet would better document their displayed maladaptive behavior. The current data sheet comprehensively documents each maladaptive behavior. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all maladaptive behavior displayed by a resident is documented on a comprehensive data sheet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 237	Continued From page 31 Individual #1's BIP, dated 3/12/10, stated he engaged in the following maladaptive behavior: - Uncooperative behavior (defined as refusing to listen and follow directions and dropping to the floor). - Physical aggression (defined as hitting, biting, pinching, scratching, kicking, shoving, and head butting). - Self abuse (defined as biting self, hitting self, and head banging). - Elopement (defined as leaving the facility without staff). Individual #1's Behavior Slips, dated 7/1/10 - 9/7/10, were reviewed. The Slips contained three sections titled Antecedent, Behavior, and Consequence. Staff were required to complete the Antecedent and Behavior section in a narrative format. However, under the section titled Consequence was a list of interventions. Staff were to circle whether the BIP was followed and document the number of times each intervention was used. The Consequence data did not clearly specify when the interventions were used in relation to the exhibited maladaptive behaviors and there was no information related to Individual #1's response to the interventions. For example, Individual #1's Behavior Slip, dated 1/5/10 at 4:25 p.m., showed the following: - Antecedent: "were [sic] going to start cooking	W 237	**The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing the current data collection systems to assure that comprehensive data is collected. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 237	Continued From page 32 dinner and [Individual #1] tried to go out the dining room door." - Behavior: "[Individual #1] attempted elopement once, I blocked him from leaving the house. He fell back (made himself fall backwards) to the ground and hit his head on edge of chair [sic]. Hit staff 4 times and kicked staff 5 times. Banged [sic] head on wall 4 times and attempted to head bang wall 3 times. Behavior lasted 5 minutes. was [sic] screaming and screaming for another 5 min. in [sic] total 10 min." - Consequence: Verbal cues: 18 times. Open hand block: 4 times. It was not clear at what point in time verbal cues and open hand blocking occurred in relation to Individual #1's maladaptive behavior. Further, Individual #1's response to the interventions was not documented. When asked, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., the type of data collection was not adequate. 2. Individual #2's IPP, dated 4/29/10, documented a 19 year old male diagnosed with profound mental retardation and autism. Individual #2's BIP, dated 5/20/10 and revised 8/10/10, stated he engaged in the following maladaptive behavior: - Inappropriate social behaviors (defined as spitting and burping loudly). - Property destruction (defined as throwing and breaking his glasses and throwing objects).	W 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 237	Continued From page 33 - Uncooperative behavior (defined as refusals and attempts to elope [leaving facility property unaccompanied by staff]). - Aggression (defined as hitting, slapping, scratching others, and throwing objects). - Self abuse (defined as biting self causing skin damage, pinching self causing skin damage and hitting self). Individual #2's Behavior Slips, dated 7/1/10 - 9/7/10, were reviewed. The Slips contained three sections titled Antecedent, Behavior, and Consequence. Staff were required to complete the Antecedent and Behavior section in a narrative format. However, under the section titled Consequence was a list of interventions. Staff were to circle whether the BIP was followed and document the number of times each intervention was used. The Consequence data did not clearly specify when the interventions were used in relation to the exhibited maladaptive behaviors and there was no information related to Individual #2's response to the interventions. For example, Individual #2's Behavior Slip, dated 8/23/10 from 2:00 - 2:30 p.m., showed the following: - Antecedent: "attempting to do fine motor activities, pegs, string beads [sic]." - Behavior: Hit 8 times, spit 3 times, burped 2 times, refused to follow directions 15 times, and	W 237		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 237	Continued From page 34 ran outside 1 time. - Consequence: Verbal cues: 31 times. Open hand blocks: 15 times. Spitting mask: 3 times. Burping audibly/Say "sorry:" 1 time. It was not clear at what point in time verbal cues and open hand blocking occurred in relation to Individual #2's maladaptive behavior. Further, Individual #2's response to the interventions was not documented. When asked, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., the type of data collection was not adequate. Without comprehensive data regarding the consequence of the behavior, it would not be possible for the facility to adequately assess whether or not the individuals' behavior intervention strategies were adequate. Further, the facility would not be able to identify whether or not the staff implemented the appropriate intervention, and whether or not the intervention was effective. The facility failed to ensure the type of data collected for individuals' maladaptive behaviors provided sufficient information to adequately assess the efficacy of the intervention strategies.	W 237		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.	W 239	**W 239 483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN** **Preferred Community Homes held an IPP meeting for individual #1 and individual #2. An experienced QMRP was sent to the home to coordinate the IPP meeting. During the meeting their behavior needs were discussed and**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 35 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior intervention programs for 2 of 2 individuals (Individuals #1 and #2) whose behavior intervention plans were reviewed. This resulted in individuals not receiving training to replace maladaptive behaviors. The findings include: 1. Individual #1's IPP, dated 3/12/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. Individual #1's Behavior Assessment, dated 3/5/10, stated two potential causes that elicited and sustained his maladaptive behavior were that his "Emotional needs are still not being met" and his "continued difficulty in expressing wants/needs." Individual #1's BIP, dated 3/12/10, stated he engaged in the following maladaptive behavior: - Uncooperative behavior (defined as refusing to listen and follow directions and dropping to the floor). - Physical aggression (defined as hitting, biting, pinching, scratching, kicking, shoving, and head butting). - Self abuse (defined as biting self, hitting self, and head banging).	W 239	replacement behavior objectives were identified. The new IPP's are being implemented on 10/20/10 with the replacement behavior written objectives. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that objectives for replacement behaviors are identified and implemented when needed. The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes assuring that replacement behavior objectives are included on the IPP for any resident with a formal behavior management plan. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 36 - Elopement (defined as leaving the facility without staff). However, Individual #1's record did not contain any training plans related to replacement behaviors as specified in his Behavior Assessment. When asked, the AQMRP stated on 9/15/10 at 12:45 p.m., replacement behaviors were not developed for Individual #1. 2. Individual #2's IPP, dated 4/29/10, documented a 19 year old male diagnosed with profound mental retardation and autism. Individual #2's Behavior Assessment, dated 4/1/10 and revised 8/8/10, stated that one of the potential causes that elicited and sustained his maladaptive behavior was his "continued inability to appropriately communicate his wants and needs." Individual #2's BIP, dated 5/20/10 and revised 8/10/10, stated he engaged in the following maladaptive behavior: - Inappropriate social behaviors (defined as spitting and burping loudly). - Property destruction (defined as throwing and breaking his glasses and throwing objects). - Uncooperative behavior (defined as refusals and attempts to elope [leaving facility property unaccompanied by staff]). - Aggression (defined as hitting, slapping, scratching others, and throwing objects).	W 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 37 - Self abuse (defined as biting self causing skin damage, pinching self causing skin damage and hitting self). According to Individual #2's BIP, his replacement behavior for inappropriate social behavior was to verbalize the word "Hi." His BIP showed the replacement behavior for the remaining maladaptive behaviors listed above, was for him to communicate his wants and needs using sign language. However, Individual #2's record did not contain any training plans related to the replacement behaviors as specified in his BIP. When asked, the QMRP stated on 9/16/10 at 9:55 a.m., training plans related to Individual #2's replacement behaviors were not developed. The facility failed to ensure appropriate replacement behaviors were developed to meet the needs of Individuals #1 and #2.	W 239		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it	W 249	**W 249 483.440(d)(1) PROGRAM IMPLEMENTATION** As stated in the report the following actions were taken on 9/15/10 to abate the immediate jeopardy: Ann addendum to the BIP was submitted which gave specific guidelines for individual #1's helmet use, use of a pillow and clear indicators related to individual #1's escalation. Since 9/15/10 Preferred Community Homes has assured that only MANDT certified and staff trained in his	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 38 was determined the facility failed to ensure an individual received training and services consistent with his behavior intervention program for 1 of 2 individual (Individual #1) whose behavior intervention plan and behavior slips were reviewed. This resulted in an individual experiencing ongoing head injures from self abuse. The findings include: 1. Individual #1's IPP, dated 3/12/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. Individual #1's BIP, dated 3/12/10, stated "[Individual #1] will remain safe by being provided with one to one staffing within arm's length, during waking hours..." His BIP stated his maladaptive behaviors included self abuse which was defined as biting self, hitting self, and head banging. His BIP stated if he showed signs of becoming agitated (defined a getting an angry look on his face), staff were to show him the feeling cards (Happy, Sad, and Angry) and have him pick a feeling card that best described how he was feeling. If he attempted to bang his head, his helmet was to be used for up to two minutes at a time to help keep him safe from injury. Individual #1's Incident/Accident Reports and Behavior Slips, dated 1/5/10 and 7/10 - 9/7/10, showed he continued to sustain head injuries from hitting his head, and his BIP was not implemented as written. Examples included, but were not limited to, the following:	W 249	Addendum has worked with him. By 9/26/10 all the staffs allowed to work with individual #1 were trained on his BIP. There were some staff that were not MANDT certified and others that were hired after this that were not allowed to work with him. Preferred Community Homes has conducted observations on the AM and PM shifts since 9/15/10 to assure that the BIP has been followed. Preferred Community Homes has assured that weekly behavior meetings have occurred to discuss individual #1's needs. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all Behavior Plans are implemented so that consumers are to be assisted to remain safe at all times. The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations in maintained. One part of the Quality Assurance measures includes reviewing Incident and Accident reports and doing observations to assure that each consumer within the facility is safe and that their programs are being implemented as written. In	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 39 - 1/5/10 at 4:25 p.m.: Individual #1 "went into a behavior" and "made himself fall backwards." A corresponding Nurse's Note documented he hit the back of his head on a chair and then on the corner of a wall resulting in a laceration. Individual #1 was transported to the local hospital where 8 staples were inserted to close the wound. His Behavior Slip, dated 1/5/10, documented verbal cues and open hand blocking were used; it was documented that his feeling cards and helmet were not used as per his BIP. - 7/7/10 at 3:50 p.m.: Individual #1 dropped and hit his head on the floor. He "reopened head injury" resulting in a ½ inch abrasion. His Behavior Slip documented verbal cues, open hand blocking, and body positioning were used; it was documented that his feeling cards and helmet were not used as per his BIP. - 7/12/10 at 9:30 a.m.: Individual #1 "darted" out the front door. When staff blocked him, he sat down on the sidewalk and hit his head on the cement. He "reopened cut on forehead" resulting in a ½ inch abrasion to his upper middle forehead. His Behavior Slip documented verbal cues and body positioning were used; it was documented that his feeling cards and helmet were not used as per his BIP. - 8/2/10 at 3:00 p.m.: Individual #1 hit the back of his head on the wall and on the kitchen floor. No apparent injury was sustained. However, his Behavior Slip showed he hit his head on the wall 2 times, and hit his head on the floor 3 times. Further, the Behavior Slip documented "no" next to the question as to whether his BIP was	W 249	**the event that a safety concern is identified, the Assistant to the Regional Administrator has been given the instruction to take immediate corrective action and remain in the facility until each consumer is safe from harm. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 40 followed as written. - 8/22/10 at 1:50 p.m.: Individual #1 hit his head on the living room wall. There was no apparent injury. His Behavior Slip documented "no" next to the question as to whether his BIP was followed as written. - 8/31/10 at 6:30 p.m.: Individual #1 was blocked from going outside. He hit his head on the dining room door resulting in a ½ inch abrasion with a 1 ½ inch diameter lump. His Behavior Slip showed verbal cues, open hand blocking, and body positioning were used; it was documented that his feeling cards and helmet were not used as per his BIP. - 9/1/10 at 1:00 p.m.: Individual #1 "got out the gate" [sic] and hit his head on the concrete driveway. He "opened scabbed forehead" resulting in "½ inch long [sic] reopened from 8/31/10." There was no corresponding Behavior Slip. - 9/1/10 at 4:00 p.m.: Individual #1 "got out the gate" [sic] and hit his head on the concrete driveway. He "opened scabbed forehead" resulting in an "abrased [sic] area now 1 inch in diameter." There was no corresponding Behavior Slip. - 9/2/10 from 2:00 - 3:00 p.m.: Individual #1 "banged his head on the sidewalk and on the dirt" resulting in "another ½ cm abrasion to forehead, lump 2 [inches] diameter mushy poss (possibly) fluid filled." Individual #1 was taken to the hospital for evaluation. However, there were three corresponding	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 41 Behavior Slips, dated 9/2/10, which showed the following: - At 2:00 p.m.: He hit his head on the ground 2 times; it was documented "no" next to the question as to whether his BIP was followed as written. - At 2:30 p.m.: He hit his head on the ground 2 times; it was documented "no" next to the question as to whether his BIP was followed as written. - At 3:30 p.m.: He hit his head on the table 1 time; it was documented "no" next to the question as to whether his BIP was followed as written. - 9/4/10 at 5:30 p.m.: Individual #1 ran outside and "banged his head on the grass 5 times." There were no apparent injuries. His Behavior Slip documented "no" next to the question as to whether his BIP was followed as written. - 9/7/10 at 2:45 p.m.: Individual #1 "went in to a behavior" and staff stopped him from going outside. "He went to the ground" and hit his head on the dining room floor. He "reopened the cut on his forehead." According to the Nursing Follow-Up section of the report, he sustained a "¼ inch reopen old wound [sic]." There was no corresponding Behavior Slip. After reviewing Individual #1's Incident/Accident reports the evening of 9/13/10, the Administrator, AQMRP, and RSC, who were present in the facility's office, were asked how the facility was protecting Individual #1 from ongoing head injuries. They were unable to answer. When asked, the AQMRP stated on 9/15/10 at	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249	Continued From page 42 12:45 p.m., she was aware the documentation showed Individual #1's BIP was not being implemented or followed as written, and his helmet was not being used. When asked, the QMRP stated on 9/15/10 at 1:00 p.m., if it was noted in the documentation that Individual #1's BIP was not implemented or followed, he would have called a team meeting. The QMRP reported they had team meetings but did not document them. Individual #1 required one-to-one arm's length supervision and a helmet to protect him from injuries when he hit his head. However, he continued to sustain ongoing head injuries and documentation showed his BIP was not implemented or followed as written. The facility failed to ensure Individual #1's BIP was consistently implemented and followed such that he was protected from ongoing head injuries.	W 249		
W 260	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure individuals' IPPs accurately reflected and responded to the individuals' needs for 2 of 3 individuals (Individuals #1 and #2) whose IPPs were reviewed. This resulted in individuals' IPPs not being revised to reflect their current needs and status. The findings include:	W 260	**W 260 483.440(f)(2) PROGRAM MONITORING & CHANGE** Preferred Community Homes held an IPP meeting for individual #1 and individual #2. An experienced QMRP was sent to the home to coordinate the IPP meeting. During the meeting their behavior needs were discussed and their plans were revised to include their current needs. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 43 1. Individual #2's IPP, dated 4/29/10, documented a 19 year old male diagnosed with profound mental retardation and autism. Individual #2's BIP stated he engaged in elopement behavior (defined as leaving facility property unaccompanied by staff). However, there were no instructions to staff on how to intervene if the behavior occurred. When asked, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., Individual #2 did not elope from the facility; he simply went outside to swing in the backyard. The Administrator stated it was a definition issue and Individual #2's BIP needed to be revised. 2. Individual #1's IPP, dated 3/12/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. Individual #1's IPP documented that he was currently attended a local middle school and had difficulty transitioning on and off the school bus. However, during observations conducted on 9/14/10 for a cumulative 4 hours 6 minutes, Individual #1 was not noted to attend school; his day treatment program was conducted at the facility. When asked, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., Individual #1 graduated from high school last spring and his IPP needed to be revised. The facility failed to ensure Individual #1 and	W 260	receive training from current Administrative staff including the importance of assuring that all IPP's are revised annually or as needed. The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes assuring that all IPP's are revised annually or as needed. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures. **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 260	Continued From page 44 Individual #2s' IPPs were revised.	W 260		
W 266	483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on observation, incident/accident reports, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently developed, consistently implemented, and closely monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include: 1. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 2. Refer to W227 as it relates to the facility's failure to ensure behavioral objectives were developed to address an individual's maladaptive behaviors. 3. Refer to W237 as it relates to the facility's failure to ensure data collection was sufficient to determine the efficacy of individuals' behavior intervention strategies. 4. Refer to W239 as it relates to the facility's failure to ensure the replacement plans for individuals' maladaptive behavior were developed to meet their behavioral needs.	W 266	**W 266 483.450 CLIENT BEHAVIOR & FACILITY PRACTICES** **Please refer the plans of correction given for W214, W227, W237, W239, W278, W285, W289, W312 and W313.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 266	Continued From page 45 5. Refer to W278 as it relates to the facility's failure to ensure less restrictive interventions were systematically tried and proven to be ineffective prior to implementing restrictive interventions. 6. Refer to W285 as it relates to the facility's failure to ensure that techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure an individual's safety, welfare and civil and human rights were protected. 7. Refer to W289 as it relates to the facility's failure to ensure that techniques used to manage inappropriate behavior were incorporated into the program plans. 8. Refer to W312 as it relates to the facility's failure to ensure behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed. 9. Refer to W313 as it relates to the facility's failure to ensure behavior modifying drugs were not used until the severity of the behavior was show to outweigh the associated risks of the drugs.	W 266		
W 278	483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs	W 278	**W 278 483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR** **Preferred Community Homes held an IPP meeting for individual #3. An experienced QMRP was sent to the**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 278	Continued From page 46 incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include: 1. Individual #3's 2/16/10 IPP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. During the entrance conference on 9/13/10 at 3:00 p.m., the QMRP stated Individual #3 did not have a behavior management program as he did not exhibit maladaptive behaviors. However, Individual #3's Incident/Accident Reports and Behavior Slips, from 7/1/10 - 9/13/10, documented he engaged in maladaptive behaviors that included, but were not limited to, hitting, slapping, hair pulling, screaming, elopement, non-compliance, putting objects in his mouth, and throwing items. Individual #3's Physician's Order, dated 8/2010, documented he received Risperidone (an antipsychotic drug) 3 mg each evening and Geodon (an antipsychotic drug) 80 mg each	W 278	home to coordinate the IPP meeting. During the meeting individual #3's behavior needs were discussed and their plans were revised to include their current needs. Currently Individual #3's psych medications are being reviewed at the PCH office as part of the psych clinic instead of a private physician. This way changes can be monitored and input can be taken from all team members prior to a medication being implemented. A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that lesser restrictive interventions are attempted prior to implementing restrictive components in an IPP. The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes assuring that lesser restrictive interventions are attempted prior to restrictive components in an IPP. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 278	Continued From page 47 evening. The Physician's Order did not document the purpose of the drugs. Individual #3's Written Informed Consent for Risperidone, dated 8/24/10, stated the drug "should further increase [Individual #3's] ability to follow instructions and increase his time on task." A second Written Informed Consent, dated 8/24/10, for Geodon stated the drug was to "continue to assist [Individual #3] in controlling his maladaptive behaviors." It appeared Individual #3's Risperidone and Geodon were used for behavioral intervention, but his record did not clearly define which maladaptive behaviors they were used for. During an interview on 9/16/10 from 1:05 - 1:50 p.m., the Administrator, who was also the acting QMRP, stated the drugs were for maladaptive behaviors, but he did not know which specific behaviors. Additionally, evidence of less restrictive interventions being systematically tried and proven to be ineffective prior to the use of behavior modifying drugs to could not be found in Individual #3's record. During an interview on 9/16/10 from 1:05 - 1:50 p.m., the Administrator stated he was not aware of any less restricting interventions being used prior to the use of the behavior modifying drugs, and evidence of attempted less restrictive interventions did not exist. The facility failed to ensure less restrictive interventions had been systematically tried and	W 278	**assisting with Quality Assurance measures.** **Person Responsible: Tom Moss, Assistant to the Regional Administrator** **Completion Date: 10/20/10**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 278	Continued From page 48 proven to be ineffective prior to the use of restrictive behavior modifying drugs for Individual #3.	W 278		
W 285	483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Interventions to manage inappropriate client behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure techniques to manage inappropriate behavior were employed with sufficient safeguards and supervision to ensure the safety, welfare and civil and human rights for 1 of 2 individuals (Individual #1) whose behavior intervention program was reviewed. This resulted in a lack of adequate protections related to an individual's physical safety. The findings include: 1. Individual #1's IPP, dated 3/12/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. Individual #1's BIP also showed he engaged in elopement which was defined as leaving the facility without staff. The BIP stated if he left the facility and sat somewhere that was unsafe (the middle of the road or parking lot), staff were to use his gait belt and/or a 2 person walking-moving restraint to immediately remove him from the area to ensure his safety. His BIP did not include directions to staff as to where the	W 285	**W 285 483.450(b)(2) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR** **As stated in the report the following actions were taken on 9/15/10 to abate the immediate jeopardy:** **Ann addendum to the BIP was submitted which gave specific guidelines for individual #1's helmet use, use of a pillow and clear indicators related to individual #1's escalation. Since 9/15/10 Preferred Community Homes has assured that only MANDT certified and staff trained in his Addendum has worked with him. By 9/26/10 all the staffs allowed to work with individual #1 were trained on his BIP. There were some staff that were not MANDT certified and others that were hired after this that were not allowed to work with him. Preferred Community Homes has conducted observations on the AM and PM shifts since 9/15/10 to assure that the BIP has been followed. Preferred Community Homes has assured that weekly behavior meetings have occurred to discuss individual #1's needs. During the process the team made the decision to discontinue the use of individual #1's gait belt due to the fact that it is not an effective tool to keep individual #1 from injuring himself.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 285	Continued From page 49 gait belt was to be kept. Observations were conducted at the facility on 9/14/10 for a cumulative 4 hours 6 minutes. During that time, Individual #1's staff were asked about Individual #1's gait belt. Staff reported it was kept in his bedroom or on top of the entertainment center in the living room. When asked, both the AQMRP and RSC stated on 9/15/10 at 12:45 p.m., the gait belt had not been used since sometime in 2008. However, Behavior Slips dated 7/20/10 and 9/4/10 documented the gait belt was used, and on both of those occasions, it was documented that he was in the fenced back yard of the facility, not in an unsafe area. Individual #1 required one-to-one arm's length supervision and a gait belt to remove him from unsafe areas. However, on two occasions when the belt was used, he was in the fenced back yard. Further, his gait belt was not kept within easy access of his staff and his BIP was not sufficiently developed to include directions to staff about the locality of the belt. The facility failed to ensure Individual #1's BIP was sufficiently developed to protect him from unnecessary restraint with the gait belt.	W 285	**A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all Behavior Plans are developed so that consumers are to be assisted to remain safe at all times.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations in maintained. One part of the Quality Assurance measures includes reviewing data, Incident and Accident reports and doing observations to assure that each consumer within the facility is safe and that their plan sufficiently developed to protect them from harm. In the event that a safety concern is identified, the Assistant to the Regional Administrator has been given the instruction to take immediate corrective action and remain in the facility until each consumer is safe from harm. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	
W 289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 289	Continued From page 50 This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently defined and incorporated into the program plans for 3 of 3 individuals (Individuals #1 - #3) whose program records were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' behavioral needs were met. The findings include: 1. Individual #3's 2/16/10 IPP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. During the entrance conference on 9/13/10 at 3:00 p.m., the former QMRP stated Individual #3 did not have a behavior management program as he did not exhibit maladaptive behaviors. However, Individual #3's Incident/Accident Reports, dated 7/1/10 to 9/13/10, were reviewed and documented the following: - 8/16/10 at 5:30 p.m.: Individual #3 slapped Individual #2 across the face. - 8/17/10 at 2:40 p.m.: Individual #3 hit Individual #4 on the hand. - 8/17/10 at 3:00 p.m.: Individual #3 hit Individual #4 on the arm. - 8/21/10 at 3:00 p.m.: Individual #3 hit Individual #4 on the arm. Additionally, Individual #3's record included a data tracking sheet, dated 2/10, which documented maladaptive behavior totals from 2/1/10 - 2/9/10,	W 289	**W 289 483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR** **Preferred Community Homes held IPP meetings for all individuals on 9/28/10. An experienced QMRP was sent to the home to coordinate the IPP meetings. During the meetings the behavior assessments were discussed and are being revised based on the current needs of the consumers as well as the behavior management plans. The information is being incorporated into the BIP.** **A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all needs are documented in the behavior management plans.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing the current IPP's and BIP's to verify that all needs are properly incorporated into each plan. The Administrator will immediately be**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 289	Continued From page 51 as follows: - Slaps = 565 - Attempts to hit = 6 - Grabbing = 276 - Pulling hair = 2 - Screaming = 538 - Non-compliant = 280 - Elopement = 83 - Attempts to elope = 28 - Dropping to ground = 303 - Running from staff = 79 - Putting objects in mouth = 17 - Throwing objects = 117 - Attempts to throw objects = 2 Additionally, Individual #3's Behavior Slips dated 7/1/10 - 9/15/10, documented the following maladaptive behaviors: 7/19/10 - 7/22/10: - Slaps = 12 - Attempts to hit = 0 - Grabbing = 7 - Pulling hair = 4 - Screaming = 40 - Non-compliant = 23 - Dropping to ground = 37 8/3/10 - 8/22/10: - Slaps = 3 - Attempts to hit = 2 - Grabbing = 1 - Pulling hair = 0 - Screaming = 175 - Non-compliant = 342 - Dropping to ground = 169 No Behavior Slips could be located for 9/2010.	W 289	**notified if discrepancies are found so corrective action can be taken. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 289	Continued From page 52 Individual #3's record did not contain plans to address the documented ongoing maladaptive behaviors. During an interview on 9/16/10 from 1:05 - 1:50 p.m., the Administrator stated behavioral interventions for Individual #3 had not been developed. The facility failed to ensure plans were developed to address Individual #3's ongoing maladaptive behaviors. Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently defined and incorporated into the program plans for 2 of 3 individuals (Individuals #1 and #2) whose program records were reviewed. This resulted in a lack of appropriate interventions being in place to ensure individuals' behavioral needs were met. The findings include: 1. Individual #1's IPP, dated 3/12/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. a. Individual #1's BIP, dated 3/12/10, stated his maladaptive behaviors included self abuse which was defined as biting self, hitting self, and head banging. His BIP stated if he attempted to bang his head, his helmet was to be used for up to two minutes at a time to help keep him safe from injury.	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 289	Continued From page 53 Individual #1's Incident/Accident Reports and Behavior Slips, dated 1/5/10 and 7/10 - 9/7/10, showed he continued to sustain head injuries from hitting his head and his Behavior Slips documented his helmet was not used. After reviewing Individual #1's Incident/Accident reports the evening of 9/13/10, the Administrator, AQMRP, and RSC, who were present in the facility's office, were asked how the facility was protecting Individual #1 from ongoing head injuries. They were unable to answer. When asked where the helmet was kept, the AQMRP and RSC both stated it was kept either in his bedroom or on top of the entertainment center in the living room. When asked what staff were to do if the head banging occurred in other locations, they were unable to answer. Individual #1's BIP was not sufficiently developed to include directions to staff about the locality of the helmet. b. Individual #1's BIP also showed he engaged in elopement which was defined as leaving the facility without staff. His BIP stated if he left the facility and sat somewhere that was unsafe (the middle of the road or parking lot), staff were to use his gait belt and/or a 2 person walking-moving restraint to immediately remove him from the area to ensure his safety. His BIP did not include directions to staff as to where the gait belt was to be kept. Observations were conducted at the facility on 9/14/10 for a cumulative 4 hours 6 minutes.	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 289	Continued From page 54 During that time, Individual #1's staff were asked about Individual #1's gait belt. Staff reported it was kept in his bedroom or on top of the entertainment center in the living room. When asked, both the AQMRP and RSC stated on 9/15/10 at 12:45 p.m., the gait belt had not been used since sometime in 2008. However, Behavior Slips dated 7/20/10 and 9/4/10 documented the gait belt was used and on both of those occasions, it was documented that he was in the fenced back yard of the facility, not in an unsafe area. Individual #1's BIP was not sufficiently developed to include directions to staff about the locality of the belt. 3. Individual #2's IPP, dated 4/29/10, documented a 19 year old male diagnosed with profound mental retardation and autism. During the entrance conference on 9/13/10 at 3:00 p.m., the Administrator informed the survey team that Individual #2 required one-to-one supervision due to maladaptive behavior. Observations were conducted at the facility on 9/14/10 for a cumulative 4 hours 6 minutes. During that time, Individual # 2 was noted to have a one-to-one staff person assigned to him. Individual #2's BIP, dated 5/20/10 and revised 8/10/10, stated he engaged in the following maladaptive behavior: - Inappropriate social behaviors (defined as spitting and burping loudly).	W 289		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 289	Continued From page 55 - Property destruction (defined as throwing and breaking his glasses and throwing objects). - Uncooperative behavior (defined as refusals and attempts to elope [leaving facility property unaccompanied by staff]). - Aggression (defined as hitting, slapping, scratching others, and throwing objects). - Self abuse (defined as biting self causing skin damage, pinching self causing skin damage and hitting self). However, Individual #2's BIP did not contain any information related to his one-to-one staffing needs. When asked, the Administrator stated during an interview on 9/16/10 from 1:05 - 1:50 p.m., Individual #2's one-to-one supervision requirement was not incorporated into his BIP. The facility failed to ensure Individual #2's one-to-one staffing needs were incorporated into his BIP.	W 289		
W 312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure	W 312	**W 312 483.450(e)(2) DRUG USAGE** **Preferred Community Homes held IPP meetings for all individuals on 9/28/10. An experienced QMRP was sent to the home to coordinate the IPP meetings. During individual #3's meeting the medication reduction plan was reviewed and the use of Risperidone and Geodon were incorporated into his plan.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 56 behavior modifying drugs were used only as a comprehensive part of an individual's IPP that was directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs were employed for 1 of 3 individuals (Individual #3) whose medication reduction plans was reviewed. This resulted in an individual receiving behavior modifying drugs without plans that identified the drugs usage and how they may change in relation to progress or regression. The findings include: 1. Individual #3's 2/16/10 IPP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. His Physician's Order, dated 8/10, documented he received Risperidone (an antipsychotic drug) 3 mg each evening and Geodon (an antipsychotic drug) 80 mg each evening. a. Individual #3's Psychotropic Medication Reduction Plan, dated 8/26/10, documented the criteria for reduction was the same for both drugs. The reduction criteria stated "Team will consider reducing when [Individual #3] achieves this program goal [individual #3] [sic] will be given the cue '[Individual #3] _____' sit down, stand up, come here, put hands down, wave bye bye, give me a hug, put arms up, clap your hands, turn around, jump, throw this away, shut the door, blow a kiss, turn on the light, get a tissue, turn on the music, give me 5, stomp your feet) [sic] [Individual #3] will independently follow a set of one step directions 1 time repeat 3 times [sic] 80% of trials per month for 6 consecutive months." Individual #3's Written Informed Consent for Risperidone, dated 8/24/10, stated the drug	W 312	**A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that all medications are incorporated into the IPP.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes reviewing the current medications, IPP's and BIP's to verify that all needs are properly incorporated into each plan. The Administrator will immediately be notified if discrepancies are found so corrective action can be taken. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 57 "should further increase [Individual #3's] ability to follow instructions and increase his time on task." However, a second Written Informed Consent, dated 8/24/10, for Geodon stated the drug was to "continue to assist [Individual #3] in controlling his maladaptive behaviors." The reduction criteria of following a one step direction was not consistent with the Written Informed Consents (i.e., time on task for Risperidone and undefined maladaptive behaviors for Geodon). b. Individual #3's record documented he engaged in the following ongoing maladaptive behaviors: 2/1/10 - 2/9/10: - Slaps = 565 - Attempts to hit = 6 - Grabbing = 276 - Pulling hair = 2 - Screaming = 538 - Non-compliant = 280 - Elopement = 83 - Attempts to elope = 28 - Dropping to ground = 303 - Running from staff = 79 - Putting objects in mouth = 17 - Throwing objects = 117 - Attempts to throw objects = 2 7/19/10 - 7/22/10: - Slaps = 12 - Attempts to hit = 0 - Grabbing = 7 - Pulling hair = 4 - Screaming = 40 - Non-compliant = 23	W 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 312	Continued From page 58 - Dropping to ground = 37 8/3/10 - 8/22/10: - Slaps = 3 - Attempts to hit = 2 - Grabbing = 1 - Pulling hair = 0 - Screaming = 175 - Non-compliant = 342 - Dropping to ground = 169 However, Individual #3's IPP contained an objective for following one step instructions which was tied to his communication needs, but did not contain objectives related to his ongoing maladaptive behavior, as noted above. During an interview on 9/16/10 from 1:05 - 1:50 p.m., the Administrator stated Individual #3's behavior modifying drugs were prescribed for his maladaptive behaviors. The Administrator stated Individual #3's Psychotropic Medication Reduction Plan needed to be revised. The facility failed to ensure the use of Risperidone and Geodon for Individual #3 were appropriately incorporated into a plan.	W 312		
W 313	483.450(e)(3) DRUG USAGE Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were not used until the severity	W 313	**W 313 483.450(e)(3) DRUG USAGE** **Preferred Community Homes held an IPP meeting for individual #3. An experienced QMRP was sent to the home to coordinate the IPP meeting. During the meeting individual #3's behavior needs were discussed and their plans were revised to include their current needs including plan for reducing individual #3's medications.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 313	Continued From page 59 of the behavior was shown to outweigh the associated risks of the drugs for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in an individual receiving behavior modifying drugs without the necessary justification. The findings include: 1. Individual #3's 2/16/10 IPP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. Individual #3's Physician's Order, dated 8/2010, documented he received Risperidone (an antipsychotic drug) 3 mg each evening and Geodon (an antipsychotic drug) 80 mg each evening. a. Individual #3's Written Informed Consent for Risperidone, dated 8/24/10, stated the drug "should further increase [Individual #3's] ability to follow instructions and increase his time on task." The Nursing 2011 Drug Handbook stated the side effects for Risperidone included, but were not limited to, akathisia (restless legs), somnolence, dystonia (a neurological movement disorder), headache, insomnia, agitation, anxiety, pain, parkinsonism (tremors), suicide attempt, dizziness, fever, hallucination, mania, impaired concentration, abnormal thinking and dreaming, tremor, hypoesthesia, fatigue, depression, nervousness, tachycardia (rapid heart rate), chest pain, orthostatic hypotension (blood pressure drops when standing), peripheral edema, syncope (fainting), hypertension, rhinitis (runny nose), sinusitis, pharyngitis, abnormal vision, ear disorder, constipations, nausea, vomiting, abdominal pain, increased saliva, diarrhea, urinary incontinence, increased urination, weight	W 313	**Currently Individual #3's psych medications are being reviewed at the PCH office as part of the psych clinic instead of a private physician. This way changes can be monitored and input can be taken from all team members prior to a medication being implemented.** **A new Administrator/QMRP has been hired and assigned to work at the Courtyard Facility. Her first day will be 10/13/10. The new Administrator will receive training from current Administrative staff including the importance of assuring that the harmful effects clearly outweigh the benefits of medication changes before medications are implemented.** **The Assistant to the Regional Administrator has been assigned to provide supervision to the Courtyard ICF/MR. He will spend a minimum of four days per month in the Wendell area completing Quality Assurance measures to assure that compliance with regulations is maintained. One part of the Quality Assurance measures includes assuring that the benefits of medications clearly outweigh the harmful effects of the drugs for all residents. The Administrator will immediately be notified if discrepancies are found so corrective action can be taken. After the program Administrator has displayed a clear understanding of the Quality Assurance Process, she will be assisting with Quality Assurance measures.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 313	Continued From page 60 gain or loss, hyperglycemia, and upper respiratory infection. Individual #3's record did not contain documented evidence that his inability to follow instructions or remain on task outweighed the potentially harmful effects of Risperidone. b. A Written Informed Consent, dated 8/24/10, for Geodon stated the drug was to "continue to assist [Individual #3] in controlling his maladaptive behaviors." However, the consent did not define "maladaptive behaviors." Individual #3's record documented Geodon was ordered on 8/23/10. The Nursing 2011 Drug Handbook stated the side effects for Geodon included, but were not limited to, dizziness, headache, somnolence, suicide attempt, akathisia, extrapyramidal symptoms (involuntary muscle movements), hypertonia (muscle contracture), asthenia (weakness, lack of energy), dystonia, anxiety, insomnia, agitation, cogwheel rigidity (jerking motions of the joints and muscles), paresthesia (numbness), personality disorder, psychosis, bradycardia (slow heart rate), QT interval prolongation (an irregularity of the electrical activity of the heart that places an individual at risk for ventricular arrhythmias), orthostatic hypotension, tachycardia, hypertension (high blood pressure), rhinitis, abnormal vision, nausea, constipation, dyspepsia (indigestion), diarrhea, abdominal pain, rectal hemorrhage, vomiting, hyperglycemia (high blood sugar), and rash. During the entrance conference on 9/13/10 at 3:00 p.m., the previous QMRP stated Individual #3 did not have a behavior management program as he did not exhibit maladaptive behaviors.	W 313	**Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 313	Continued From page 61 Additionally, Individual #3's IPP did not include objectives related to "controlling his maladaptive behaviors." Individual #3's record did not contain documented evidence that the harmful effects of his unidentified maladaptive behaviors had been assessed to determine if they outweighed the potentially harmful effects of the Geodon prior to its use. During an interview on 9/16/10 from 1:05 - 1:50 p.m., the Administrator stated there was no documentation that could show the harmful effects of Individual #3's maladaptive behaviors outweighed the potential risks of the drugs prescribed to manage those behaviors. The facility failed to ensure Individual #3's Risperidone and Geodon were used only after the risks of the behaviors for which they were prescribed were clearly shown to outweigh the potential side effects of the drugs.	W 313		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM164	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124.	MM164	**MM164 16.03.11.075.04 DEVELOPMENT OF PLAN OF CARE** **Please refer to plan of correction given for W124.** RECEIVED OCT 20 2010 FACILITY STANDARDS	
MM177	16.03.11.075.09 Protection from Abuse and Restraint Protection from Abuse and Unwarranted Restraints. Each resident admitted to the facility must be protected from mental and physical abuse, and free from chemical and physical restraints except when authorized in writing by a physician for a specified period of time, or when necessary in an emergency to protect the resident from injury to himself or to others (See also Subsection 075.10). This Rule is not met as evidenced by: Refer to W122, W127 and W285.	MM177	**MM177 16.03.11.075.09 PROTECTION FROM ABUSE AND RESTRAINT** **Please refer to the plan of correction given for W122, W127 and W285**	
MM191	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of	MM191	**MM191 16.03.11.075.09(c) LAST RESORT** **Please refer to plan of correction given for W278 and W313.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM191	Continued From page 1 physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W278 and W313.	MM191		
MM195	16.03.11.075.10(b) Developed and Reviewed Has been developed and reviewed by a qualified mental retardation professional; and This Rule is not met as evidenced by: Refer to W289.	MM195	**MM195 16.03.11.075.10(b) DEVELOPED AND REVIEWED** Please refer to plan of correction given for W289.	
MM197	16.03.11.075.10(d) Written Plans Is described in written plans that are kept on file in the facility; and This Rule is not met as evidenced by: Refer to W312.	MM197	**MM197 16.03.11.075.10(d) WRITTEN PLANS** Please refer to plan of correction given for W312.	
MM209	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137.	MM209	**MM209 16.03.11.075.15 RIGHT TO PERSONAL ITEMS** Please refer to plan of correction given for W137.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM212	Continued From page 2	MM212		
MM212	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W266.	MM212	**MM212 16.03.11.075.17(a) MAXIMIZE DEVELOPMENTAL POTENTIAL** **Please refer to plan of correction given for W266.**	
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all toxic chemicals were properly stored under lock and key for 7 of 7 individuals (Individuals #1 - #7) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals. The findings include: 1. During an environmental review on 9/14/10 from 6:50 - 8:00 a.m., the following toxic chemicals were found to be unlocked: a. In the laundry room: - Two 1.5 gallon bottles of Clorox Bleach. - 1 Bottle Great Value Glass Cleaner. - 1 can of Sprayway Glass Cleaner. - 1 plastic spray bottle labeled "Clorox with soap." - 1 spray bottle of Clorox Clean Up with Bleach - Two 2 quart bottles of Clorox Clean Up with Bleach. b. Under the kitchen sink: - 1 can of Sprayway Glass Cleaner.	MM271	**MM271 16.03.11.100.04(b) STORAGE OF TOXIC CHEMICALS** **The facility has been inspected and currently all chemicals are labeled and under lock and key. Training will be provided to all employees on the regulation and all staff will ensure all chemicals are properly labeled and locked. In addition, the program Administrator will be assigned to do monthly inspections of the facility. One part of the inspection includes the Administrator looking for any chemicals not labeled or kept under lock and key. In the event that any chemicals are located that are not labeled or under lock and key, immediate corrective action will occur.** **Person Responsible:** Tom Moss, Assistant to the Regional Administrator **Completion Date:** 10/20/10	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM271	Continued From page 3	MM271		

- 1 plastic spray bottle of Windex Glass Cleaner.
- 1 plastic spray bottle of Western Family Antibacterial Cleaner with a masking tape label that stated "Fabreeze."

c. In the garage where individuals bicycles were stored:
- One 2 gallon bottle Total Kill Weed and Grass Killer.
- One 1.5 gallon bottle of Clorox Bleach.
- 1 can of WD-40.
- 1 can of Spectracide Wasp and Hornet Killer.
- 1 bottle of Western Family Anit-Freeze.
- 3 bottles of Inspecta Shield Fire Retardant.
- 1 bottle of Ferti-lome Root Stimulator.
- 1 bottle of STP Power Steering Fluid.
- 1 bottle of Western Family BBQ Lighter Fluid.

The MSDS (Material Safety Data Sheet) for Clorox Clean Up with Bleach stated the product could irritate skin, eyes, nose, throat, and lungs, and was harmful if swallowed.

The MSDS for Great Value Glass Cleaner and Windex Glass Cleaner stated harmful if swallowed, could cause eye irritation, and could cause irritation if inhaled.

The MSDS for Sprayway Glass Cleaner stated the product was classified as a "Hazardous Chemical" and was harmful to skin, kidneys, blood, and liver.

The MSDS for Fabreeze stated the product was harmful if inhaled or ingested.

The MSDS for Total Kill Weed and Grass Killer stated the product was harmful if ingested, and caused eye and skin irritation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM271	Continued From page 4 The MSDS for WD-40 stated the product was harmful if inhaled or swallowed. The MSDS for Spectracide Wasp and Hornet Killer stated the product was harmful if ingested, and caused eye and skin irritation. The MSDS for Western Family Anit-Freeze stated the product was harmful or fatale if swallowed. The MSDS for Inspecta Shield Fire Retardant stated the product was harmful if swallowed, and could cause skin and eye irritation. The MSDS for Ferti-lome Root Stimulator stated the product was harmful if swallowed, and could cause skin and eye irritation. The MSDS for STP Power Steering Fluid stated the product was harmful if swallowed, and could cause skin and eye irritation. The MSDS for Western Family BBQ Lighter Fluid stated the product could cause eye, skin, and lung irritation, was harmful if swallowed, and could cause kidney, brain, and nerve damage. The Residential Service Coordinator (RSC), who was present during the review, stated Individual #6 was known to place items in his mouth. The RSC stated the chemicals should have been locked. The facility failed to ensure all toxic chemicals were maintained under locked conditions. Repeat deficiency	MM271		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM620	Continued From page 5	MM620		
MM620	16.03.11.230.05(b) Upgrading of Competencies The upgrading of competencies to improve skills based on resident needs and corresponding staff expertise; and This Rule is not met as evidenced by: Refer to W193 and W249.	MM620	**MM620 16.03.11.230.05(b) UPGRADING OF COMPETENCIES** Please refer to plan of correction given for W193 and W249.	
MM725	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159.	MM725	**MM725 16.03.11.270.01(b) QMRP** Please refer to plan of correction given for W159.	
MM726	16.03.11.270.01(c) Individual Resident Treatment Plan In addition to the participation of the IDT, the individual resident treatment plan will be developed with the participation of: This Rule is not met as evidenced by: Refer to W207.	MM726	**MM726 16.03.11.270.01(c) INDIVIDUAL RESIDENT TREATMENT PLAN** Please refer to plan of correction given for W207.	
MM729	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by: Refer to W227.	MM729	**MM729 16.03.11.270.01(d) TREATMENT PLAN OBJECTIVES** Please refer to plan of correction given for W227.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM729	Continued From page 6	MM729		
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	**MM730 16.03.11.270.01(d)(i) DIAGNOSTIC AND PROGNOSTIC DATA** Please refer to plan of correction given for W214.	
MM731	16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by: Refer to W237.	MM731	**MM731 16.03.11.270.01(d) MEASURABLE BEHAVIORAL TERMS** Please refer to plan of correction given for W237.	
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W239.	MM855	**MM855 16.03.11.270.08(c) TRAINING AND HABILITATION RECORD** Please refer to plan of correction given for W239.	
MM861	16.03.11.270.08(f)(iii) Periodic Review Initiating periodic review of each individual plan of care for necessary modifications or adjustments. This Rule is not met as evidenced by: Refer to W260.	MM861	**MM861 16.03.11.270.08(f)(iii) PERIODIC REVIEW** Please refer to plan of correction given for W260.	

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	C 09/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTY/	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM861	Continued From page 7	MM861		